TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jay Harrison, D.C.

Respondent Name
Safety First Insurance Company

MFDR Tracking Number
M4-17-0012-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 2, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on September 12, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2016	Designated Doctor Examination	$650.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services performed

March 1, 2008 until September 1, 2016.

3. Texas Labor Code §408.0041 defines the requirements for designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization.
   - X435 – Based on chiropractic peer review, further treatment is not recommended.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are Safety First Insurance Company's reasons for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the services in question?

Findings

1. Jay Harrison, D.C. is seeking reimbursement of $650.00 for a designated doctor examination performed on March 9, 2016, as requested by Safety First Insurance Company and ordered by the division. Safety First Insurance Company denied the designated doctor examination with claim adjustment reason codes 216 – "Based on the findings of a review organization," and X435 – "Based on chiropractic peer review, further treatment is not recommended."

   Texas Labor Code §408.0041(a) gives the commissioner the authority to order a medical examination to resolve any question about:

   (1) the impairment caused by the compensable injury;
   (2) the attainment of maximum medical improvement;
   (3) the extent of the employee's compensable injury;
   (4) whether the injured employee's disability is a direct result of the work-related injury;
   (5) the ability of the employee to return to work; or
   (6) issues similar to those described by Subdivisions (1)-(5).

   Texas Labor Code §408.0041(h) further states that the insurance carrier **shall** pay for a medical examination ordered by the commissioner to resolve such questions, "unless otherwise prohibited by this subtitle or by an order or rule of the commissioner."

   The division finds that a designated doctor examination ordered by the commissioner is not subject to retrospective review for medical necessity. Safety First Insurance Company's reasons for denial of payment for the designated doctor examination in question are not supported. The division finds that the requestor is entitled to reimbursement for the disputed services.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lumbar spine. Therefore, the correct MAR for this examination is $300.00.

   The total MAR for the designated doctor examination in question is $650.00. This reimbursement amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	November 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.